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ABSTRACT

This study examined the demographic, service use, and juvenile justice history associated with clinical variables in a juvenile justice population. Records of 3,283 youth (ages 10 to 18) admitted to a juvenile corrections facility in a six-month period were reviewed. Of this group, 244 (8 percent) had been referred for mental health evaluation. Both African-Americans and Caucasians were referred for mental health evaluation at a substantially higher rate than Latino youth and being a minority was associated with receiving a diagnosis of conduct disorder. The report notes the relatively low rate of referral in a population with an estimated prevalence of emotional disturbance of 14-22 percent. (DB)

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The Characteristics of Youth Referred for Mental Health Evaluation in the Juvenile Justice System

Introduction

Many of the youths detained in juvenile detention facilities in the United States suffer from emotional disorders. Youth detained in corrections facilities have been found to have levels of psychopathology similar to the levels of mental illness found in psychiatric hospitals (Davis, Bean, Schumacher & Stringer, 1991; Pumariega, 1996). Because many of these youths reside in low socioeconomic status neighborhoods where there are few mental health services, their emotional difficulties are likely to go untreated prior to incarceration. Few juvenile justice facilities provide extensive mental health services after incarceration (Anno, 1984). Therefore, the mental health needs of this population generally receive inadequate attention.

It is unclear which factors are associated with youth being referred for mental health evaluation and treatment once incarcerated. There is considerable evidence to suggest that there are racial and gender biases that affect who is detained, but there is little evidence as to whether these differences persist when considering who is referred for services. There is, however, evidence to suggest that differences exist in how youth from different racial or ethnic groups are diagnosed. African American youth are more likely to receive a diagnosis of conduct disorder (Fabrega, Ulrich, & Mezzich, 1993). When they do receive a non-conduct disorder Axis I diagnosis, African American youth are more likely to receive an inappropriate diagnosis (Kilgus,

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Pumariega, & Cuffe, 1995). This inappropriate diagnostic labeling may impact the likelihood that youth receive appropriate treatment and experience favorable outcomes.

Beyond the characteristics of race and gender, there is a lack of information in the literature on the characteristics of referred youth. It is unclear whether other demographic characteristics, service use patterns, and juvenile justice history affect the mental health service needs of detained youth.

As a first step toward improving the process of detection of mental health problems and appropriate referral, we studied the referral process in one southern California juvenile justice facility. We examined the demographic, service use, and juvenile justice history variables and their association with three clinical variables in a juvenile justice population. Our working hypotheses were that:

1. youth of minority racial/ethnic status would be less likely to be referred for mental health treatment;
2. minority racial/ethnic status would be positively associated with receiving a diagnosis of conduct disorder; and
3. previous mental health service use would be positively associated with the youth receiving a DSM diagnosis other than conduct disorder.

Methods

The data for this study was obtained by reviewing the probation department records on all youth admitted to a juvenile corrections facility in a six month period ($N = 3283$). Additionally, the mental health department records were reviewed on all youth referred for mental health evaluation/treatment during the same six month period ($N = 244$). All youth were between 10 and 18 years of age and included both pre- and post-adjudicated youth. The youth were referred for mental health evaluation by nursing staff on intake, detention staff members who work directly with youth on one of 10 housing units, teachers at the school located on the grounds of the juvenile hall, probation officers who worked with the youth prior to detention, or by parents who could contact the mental health staff directly. There was no formal mental health evaluation either at the time of intake or at any time during the youth's stay in juvenile hall.

Variables Studied

Two factors were examined as independent variables in this study:

1. ***Internalizing Behavior:*** Youth were placed in the internalizing category if they were reported to have the following behaviors: (a) verbal expressions of self harm that were not accompanied by other behavioral problems; (b) sadness and tearfulness; and (c) withdrawn behavior in the absence of other behavioral symptoms. Youth with violent, assaultive, aggressive, or bizarre (as defined by staff) behavior were placed in the externalizing category.
2. ***Primary Diagnosis:*** The primary psychiatric diagnoses were divided into two groups: (a) disorders for which there was a well prescribed outpatient treatment (adjustment disorders, major affective disorders, anxiety disorders, psychotic disorders, and impulse control disorders); and (b) conduct disorders which do not have a clearly defined outpatient treatment that could be administered to youth over a short period of time in this facility.

The following factors were employed as dependent variables in this study: (a) gender; (b) race/ethnicity (Black, Latino, White, and other); (c) age; (d) past mental health service use; (e) age at first arrest; (f) repeat offender; and (g) violent index offense. Each youth was classified as being a violent offender if his/her index offense (which resulted in incarceration) was one in which physical

force, or the threat of force, was used against another individual, or a weapon was used in the commission of the crime. These included murder, attempted murder, rape and sexual assault, assault with a deadly weapon, assault and battery, and robbery (if a weapon was used).

Chi-square tests and *t* tests were used to compare the total juvenile hall population to the youth referred for mental health evaluation. The association of the independent variables with the dependent variables was explored using two logistic regression models.

Results

The total number of youth referred for mental health evaluation was 244 which represented 8% of the juvenile hall population. Females and non-Hispanic youth, including African American youth, were referred at a higher rate than male and Latino youth (see Table 1). A larger number of the referred youth were repeat offenders and were more likely to have committed violent crimes.

Table 1
Characteristics of Detained Youth:
L.A. County Juvenile Hall, 1995

	Referred (n = 244)	All (n = 3283)
Gender		
Male (%)	178 (73.0)	2771 (84.4) **
Race/Ethnicity		
African American (%)	72 (29.5)	770 (23.4) *
White (%)	94 (38.5)	722 (22.0) **
Latino (%)	71 (29.1)	1661 (50.6) **
Other (%)	7 (2.9)	130 (4.0) *
Mean Age (*SD*)	15.6 (1.5)	15.9 (1.5) *
First Time Offenders (%)	140 (57.3)	2601 (79.2) **
Violent Crimes	81 (33.2)	698 (21.3) **
Mean Age at First Arrest	13.9 (1.8)	13.8 (1.6)

* $p < .05$ ** $p < .001$

Among the referred sample, 123 (50%) of the youth reported the current use of alcohol and drugs. Almost half (56) of these youth reported using three or more drugs on a frequent basis. Despite having a significant rate of alcohol and substance use, only five of the 123 youth who stated that they had used alcohol or drugs received a primary diagnosis of substance use disorder. Forty-one youth had a secondary diagnosis of a substance use disorder.

Ninety-seven percent of all referred youth met the DSM IV diagnostic criteria for a psychiatric disorder and received the following diagnoses: Adjustment Disorder (34%), Conduct Disorder (25%), Affective Disorders (13%), Attention Deficit Hyperactivity Disorder (14%), Psychotic Disorders (5%), Post-Traumatic Stress Disorder (4%), and Substance Use Disorders (2%). The diagnostic categories differed based on the job classification of the referrer. For example, those with a diagnosis of conduct disorder were more likely to be referred by probation staff who work directly with the youth on a daily basis (72%) while those who had a psychiatric disorder other than conduct disorder were more likely to be referred by nursing staff (50%).

The two logistic regressions used to examine the impact of demographic, service use, and juvenile justice history variables are presented in Tables 2 and 3. Table 2 shows the association of these factors to internalizing behavior. Youth with a history of prior mental health service use and those with a violent index offense were almost half as likely to be referred to mental health for internalizing symptoms than for aggressive, bizarre, or agitated behavior. Repeat offenders were twice as likely to be referred for depressive symptoms.

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Table 3 shows the results of the regression examining the effects of the variables on psychiatric diagnosis. Minority youth were almost twice as likely to receive a diagnosis of conduct disorder than non-minority youth. Mental health service use was also significant in determining the psychiatric diagnosis. Juveniles who had previously utilized mental health services were more likely to receive a diagnosis other than conduct disorder.

Discussion

It is disturbing that referred youth represented under 8% of the juvenile hall population since the prevalence of emotional disturbance in this population is conservatively estimated at 14-22% (Otto, 1991). The lack of identification and treatment of the mental health problems of the non-referred youth may have serious and long range consequences. These potentially include future crime and incarceration, poverty, chronic emotional suffering, and persistent substance abuse.

Our study found that both African-Americans and Caucasians were referred at a higher rate while the Latino youth were referred at a much lower rate. The slight over representation of African Americans in the referred sample is inconsistent with our hypothesis and with the former studies. One possible explanation for these findings is the racial makeup of the juvenile hall staff, which is predominantly African American. Staff members from similar ethnic backgrounds as the youth may have a higher sensitivity for abnormal behaviors in youth from similar cultures. The cultural differences which exist between African American staff and Latino youth, who may be recently immigrated and/or speak English as a second language, may account for staff being less likely to recognize psychopathology in Latino youth. This is especially true if there are no significant behavioral problems.

Being a minority was associated with receiving a diagnosis of conduct disorder when we controlled for the other independent variables. Minority youth were almost twice as likely to receive a diagnosis of conduct disorder than Caucasian youth. Because we do not have an objective measure of psychopathology, we cannot state that there was a diagnostic bias present, however, the present evidence suggests that bias might exist in the diagnoses assigned to minority youth. Cultural factors that affect the expression of psychopathology have also been offered as an

Table 2
Logistic Regression to Explain Internalizing Behavior as the Reason for Referral *

	Coefficient	Odds Ratio	95% Confidence Interval	*p* value
Demographic				
Male	-.522	.59	.31-1.13	.11
Minority	.000	1.00	.53-1.87	.99
Age	-.084	.91	.48-1.72	.79
Service Use History				
Mental Health Service Use	-.610	.54	.29-1.00	.05
Juvenile Justice History				
Age at First Arrest	.484	1.62	.83-3.14	.15
Repeat Offender	.746	2.11	1.11-4.01	.02
Violent Index Offense	-.674	.51	.26-1.00	.05

* The 95% CI is based on odds ratios.

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explanation to explain similar findings (Cross, Bazron, Dennis, & Isaacs, 1989). Although almost 60% of the youth that were referred to mental health were from minority racial/ethnic backgrounds, there were no minority mental health staff at this facility. Cultural, social, and economic differences between the mental health staff and the youth that they treat which impact the outcomes of diagnostic evaluation.

Despite the limitations of this study, it is a first step in understanding the clinical service needs of a population of youth housed in a short term juvenile corrections facility. The study found clear patterns in terms of under-representation of Latino youth among those referred for mental health services, and the increased likelihood that both Latino and African-American youth are given a primary diagnosis of conduct disorder rather than another DSM IV Axis I disorder. Additionally, youth who received previous mental health services were less likely to receive a diagnosis of conduct disorder and more likely to receive another Axis I diagnosis.

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Table 3
Logistic Regression to Explain Primary Diagnosis *

Variables	Coefficient	Odds Ratio	95% Confidence Interval	*p* value
Demographic				
Male	-.109	.93	.48-1.79	.82
Minority	-.519	.54	.29-1.00	.05
Age	.001	.97	.78-1.21	.82
Service Use History				
Mental Health Service Use	.858	2.07	1.10-3.88	.02
Juvenile Justice History				
Age at First Arrest	.156	.85	.70-1.03	.10
Repeat Offenders	.055	1.00	.52-1.91	.99
Violent Index Offense	.351	1.15	.89-1.50	.28

* The 95% CI is based on odds ratios

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